CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

l i i i i i i i i i i i i i i i i i i i			ULTIPLE CC	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		15G475	B. WIN	G		10/07/20	)11
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SOLITEIER				LLSWORTH CT		
ARC BRI	DGES INC			MERRII	LLVILLE, IN46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0000							
			137	0000			
		6 1 1	W	0000			
	This visit was for						
	recertification an	d state licensure survey.					
	<u> </u>	October 3, 4, 5, and 7,					
	2011						
	Facility number:						
	Provider number	: 15G475					
	AIM number: 10	00244900					
	Surveyors:						
	Tim Shebel, Med	lical Surveyor III-Team					
	Leader	•					
	Christine Colon.	Medical Surveyor III					
	The following fe	deral deficiencies also					
	_	ngs in accordance with					
	460 IAC 9.	ngs in accordance with					
		completed 10/20/11 by					
	Chris Greeney, M	•					
		•					
	Supervisor and R	· ·					
	Medical Surveyo	or 111.					
W0104	The governing boo	dy must exercise general					
	policy, budget, and	d operating direction over					
	the facility.				0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		ation, record review and	W	0104	Clients #1, 2, 3, & 4 will be		11/07/2011
		verning body failed for 4			reimbursed for haircut and hygiene products purchased		
	of 5 clients (clien	nts #1, #2, #3 and #4)			To ensure future compliance		
LADODATOD	V DIDECTOR'S OR DROY	/IDER/SUPPLIER REPRESENTATIVE'S SI	CNATIDI	3	TITLE		(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	i i			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G475	B. WIN	G		10/07/20	n1
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					LSWORTH CT		
	IDGES INC			MERRIL	LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	Service Coordinator will audi	+	DATE
		ip home, to exercise			their budgets twice monthly.	`	
	, ,	g direction in a manner 1.			Service Coordinator will re-tra		
		s did not pay for hair cuts			the DSP to call for permission	n to	
		ducts and 2. To provide			withdraw any money from Cli	ients	
	_	re their "Policy for			accounts.  To ensure future compliance		
	_	of Neglect and Abuse"			Service Coordinator will audi		
	was implemente	ed.			client's bank accounts month		
					three months, and budgets w		
	Findings include	· ·			audited twice monthly.	, <sub>e</sub>	
					The missing money for client #1, 2, 3, & 4 were reimbursed		
		he facility's records was			October 7, 2011.		
		facility's administrative			All of the DSPs in the group I	home	
	office on 10/4/11	1 at 11:50 A.M A			have been trained to call the		
	financial record	review for clients #1, #2,			Service Coordinator for	, to	
	#3 and #4 was co	ompleted. The financial			permission to take the clients the bank to withdraw any mo		
	review indicated	client #1 had paid for a			from their accounts. To ensu		
	hair cut on 1/6/1	1 in the amount of			future compliance, Service		
	\$10.00. The rec	cord also indicated:			Coordinator will monitor with		
	"Receipt dated 12	2/20/10body wash			following protective measure: Clients must be present during		
	_	incial record review			any banking activity on their	יש	
		#2 paid for a haircut on			accounts. Service Coordinate	or will	
		ount of \$10.00. The			compare the budgets, bank		
		ated: "Receipt dated			withdraws and deposits slips	to	
		wash \$3.47, body wash			the bank activity/statements monthly.		
	1	h \$3.47, bath soap \$3.76."			monuny.		
		cord review indicated					
		r a hair cut on 1/6/11 in					
	-	0.00. The financial					
		dicated client #4 paid for					
		11 in the amount of					
		review of client #1, #2,					
		rds did not indicate they					
		for the mentioned					
		TOT THE HIGHHOREA					
	expenses.						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	CPKK11	Facility II	D: 000989 If continuation sh	heet Pag	e 2 of 48

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MU A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPLI 10/07/20	ETED	
NAME OF PROVIDER OR SUPPLIER  ARC BRIDGES INC			p. white	STREET A	DDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	10/4/11 at 12:20 clients #1, #2, #3	h the Service ) was conducted on P.M The SC indicated and #4 had not been ne mentioned expenses.					
	conducted on 10/ Review of the factoric record indicated reports and Bures	ne facility's records was 44/11 at 10:40 A.M cility's investigation internal incident/accident au of Developmental ices (BDDS) reports the following:					
	and 4/9/11, date of "Someone has m or 4/11/11 out of accountReport (SC)To (sic) m to the clients more separation of dut	to Service Coordinator any people have access ney. There is no ies." Further review of to indicate the amount of					
	and 3/23/11: "So withdrawal out o accountReport (SC)To (sic) m to the clients more	dent report dated 4/11/11 pmeone has made f [client #2]'s savings to Service Coordinator any people have access ney. There is no ies." Further review of					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G475	A. BUILD B. WING			10/07/2	011
NAME OF I	PROVIDER OR SUPPLIER		p. Wilde		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					LSWORTH CT		
ARC BR	IDGES INC			MERRIL	LVILLE, IN46410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	D	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	r.	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	the report failed	to indicate the amount of					
	money withdraw	n.					
	C. Incident/Acc and 5/23/11: "So withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut the report failed money withdraw	ident report dated 4/11/11 comeone has made of [client #3]'s to Service Coordinator cany people have access ney. There is no cies." Further review of to indicate the amount of cn. ident report dated					
	withdrawals out accountReport	of [client #4]'s savings to Service Coordinator any people have access					
	to the clients mo	_					
	_	ies." Further review of					
	money withdraw	to indicate the amount of					
	money withdraw	11.					
	E. BDDS report	dated 7/19/11: "Staff					
		Coordinator that when					
		eank with a client (client					
	· ·	emed to be money					
	_	accountService ted gathering information					
		/11 received bank					
		ce: 7/17/11 conducted					
	internal investigation and found monies to						
	_	visiting group home;					
	7/18/11 received	other deposit withdraws					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		A. BUII	LDING	NSTRUCTION  00	(X3) DATE COMPL 10/07/2	ETED	
	PROVIDER OR SUPPLIEF		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  LSWORTH CT  LVILLE, IN46410	<u> </u>	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	in the inner-offic			TAG	DEFICIENCY)		DATE
	F. BDDS report notified Service she went to the best was account: 7/12 statement in officinternal investigate be missing after 7/18/11 received in the inner-offic requested formal G. BDDS report notified Service she went to the best was account: 7/12 statement in officinternal investigate went to the best was account: 7/12 statement in officinternal investigate missing after 7/18/11 received in the inner-officinternal investigate missing after 7/18/11 received in the inner-officinternal investigate missing after 7/18/11 received in the inner-officinternal investigate formal H. BDDS report notified Service	internal investigation."  I dated 7/19/11: "Staff Coordinator that when bank with a client (client emed to be money accountService ted gathering information /11 received bank ce: 7/17/11 conducted ation and found monies to visiting group home; other deposit withdraws					

000989

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		LDING	NSTRUCTION  00	(X3) DATE : COMPL 10/07/2	ETED	
	PROVIDER OR SUPPLIER	2	5777 EL	NDDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
	#4) that there see missing from his Coordinator star to account: 7/12 statement in offi internal investigate missing after 7/18/11 received in the inner-office requested formal.  Further review of indicated:  1. Staff/Client II Sheet: "Incident 15539[Client #4 review of the regamount of mone.  2. Staff/Client II Sheet: "Incident 15538[Client #6/30/11Someo on 4/9/11 or 4/1 account." Further failed to indicate withdrawn.  3. Staff/Client II Staff/Client II Sheet: "Incident #4 review of the regamount of mone.	emed to be money accountService ted gathering information //11 received bank ce: 7/17/11 conducted ation and found monies to visiting group home; dother deposit withdraws the mail. 7/19/11 dinternal investigation."  If the investigation record  Incident Report Summary Report Number: HallDate: In has made withdrawals I account." Further Boort failed to indicate the Ty withdrawn.  Incident Report Summary Report Number: HallDate: In has made withdrawal I account failed to indicate the Ty withdrawn.  Incident Report Summary The Report Number: Hall out of [client #1] The review of the report The the amount of money  I recident Report Summary The R				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/07/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<b>.</b>	•		ADDRESS, CITY, STATE, ZIP CODE	•	
ARC BRI	DGES INC				LLSWORTH CT LLVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
PREFIX TAG	6/30/11Someo out of his accour report failed to it money withdraw  4. Staff/Client I Sheet: "Incident 15541[Client # 6/30/11Someo out of [client #2] Further review of indicate the amount of the Se indicated: "No cor 5/23/11 for all were available-(indicated on 10 Review of client indicated a cash facility for missiclient #2's record reimbursement for the second of the	ne has made withdrawals nt." Further review of the indicate the amount of vn.  ncident Report Summary to Report Number:  #2]Date: ne has made withdrawals   savings account." of the report failed to unt of money withdrawn.  C notes dated 7/17/11 deposit slips for 4/11/11 I gentlemanBudgets		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION DATE
	missing funds. R record failed to i	from the facility for Leview of client #4's					
	missing funds.	Tom the facility 101					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G475	A. BUI B. WIN	LDING		10/07/2	011
			P. WIIV		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				LSWORTH CT		
ARC BRI	DGES INC			MERRIL	LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		facility's "Policy for		TAG	DLI ICILICI I		DATE
		of Neglect and Abuse"					
		vas conducted on 10/4/11					
		d indicated: "In order to					
		ral welfare of the clients,					
	l	has in effect the following					
		rd to abuse, neglect or					
	1	lients by agency staff					
		prohibits all abuse,					
	neglect and expl						
	_	Il immediately report any					
	allegations of ab						
		ur clients per agency					
	_	ureAll allegations of					
		umiliation or exploitation					
	_	tedExploitation-is					
		authorized use or misuse					
	of a client's labor	r, funds, property or other					
		wn profit or advantage.					
	Examples includ	e but are not limited to					
	using their finan	ces without					
	permissionThe	designated staff					
	conducting the in	vestigation will submit					
	to the Quality As	ssurance Specialist or					
	1	n as possible (preferably					
	within 24 hours)	a written summary of					
	any and all infor	mation gathered with					
	•	identUpon receipt of the					
	_	Quality Assurance					
		ignee will complete the					
	I	-up report within 5 days					
	(and thereafter as	s needed)."					
	An interview wit	th the Service					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPI 10/07/2	LETED	
	ROVIDER OR SUPPLIER		STREET A 5777 EI	ADDRESS, CITY, STATE, ZIP COE LLSWORTH CT LLVILLE, IN46410	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W0140	the reporting staft to her but she had statements to cor withdrawals. The investigation was would be reimbut funds this week. no follow up reported by a statement of the facility must esystem that assure accounting of clier entrusted to the facility failed to accounting system at the group hom #4), for whom the personal funds accountings include findings include	e SC indicated the still open and the clients red for the missing. The SC further indicated orts were submitted.  stablish and maintain a set a full and complete hts' personal funds cility on behalf of clients. review and interview, the maintain an accurate in for 4 of 5 clients living the e (clients #1, #2, #3 and the facility managed their ecounts.	W0140	See tag # 104, p. 2 Please tag 104		11/07/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15C475			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G475	B. WIN	G		10/07/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
ARC BR	IDGES INC				LLSWORTH CT LLVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	conducted on 10	0/4/11 at 10:40 A.M					
		cility's investigation					
		internal incident/accident					
	-	eau of Developmental					
		vices (BDDS) reports					
	which indicated	the following:					
	A Incident/Ass	sident report dated 1/0/11					
		e of referral 6/30/11:					
		nade withdrawal on 4/9/11					
	or 4/11/11 out or						
		to Service Coordinator					
	_	nany people have access					
	` ′ ′	oney. There is no					
		ties." Further review of					
	_	to indicate the amount of					
	money withdraw						
	B. Incident/Acc	ident report dated 4/11/11					
	and 3/23/11: "S	omeone has made					
	withdrawal out o	of [client #2]'s savings					
	accountReport	to Service Coordinator					
	(SC)To (sic) n	nany people have access					
	to the clients mo	oney. There is no					
	separation of du	ties." Further review of					
	the report failed	to indicate the amount of					
	money withdrawn.						
	C. Incident/Accident report dated 4/11/11						
	and 5/23/11: "Someone has made						
	withdrawals out of [client #3]'s						
	•	to Service Coordinator					
		nany people have access					
	to the clients mo	oney. There is no					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 10/07/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	2			DDRESS, CITY, STATE, ZIP CODE	_	
ARC BRI	DGES INC				LSWORTH CT LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
		ties." Further review of to indicate the amount of vn					
	4/11/11: "Some withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dur	of [client #4]'s savings to Service Coordinator nany people have access ney. There is no ties." Further review of to indicate the amount of					
	notified Service she went to the bull that there seemissing from his Coordinator star to account: 7/12 statement in officinternal investigate missing after 7/18/11 received in the inner-officinter-o	c dated 7/19/11: "Staff Coordinator that when bank with a client (client emed to be money accountService ted gathering information 1/11 received bank ce: 7/17/11 conducted ation and found monies to visiting group home; a other deposit withdraws be mail. 7/19/11					
	notified Service she went to the b #2) that there see missing from his	dated 7/19/11: "Staff Coordinator that when eank with a client (client emed to be money accountService ted gathering information					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE ( COMPL 10/07/2	ETED	
NAME OF	DROMDER OF GURPLASS				DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	(		5777 EL	LSWORTH CT		
ARC BR	DGES INC			MERRIL	LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		/11 received bank					
		ce: 7/17/11 conducted					
	_	ation and found monies to					
	_	visiting group home;					
		other deposit withdraws					
	in the inner-offic						
	requested formal	internal investigation."					
	_	t dated 7/19/11: "Staff					
		Coordinator that when					
	she went to the b	eank with a client (client					
	#3) that there see	emed to be money					
	missing from his	accountService					
	Coordinator start	ted gathering information					
	to account: 7/12	/11 received bank					
	statement in office	ce: 7/17/11 conducted					
	internal investiga	ation and found monies to					
	be missing after	visiting group home;					
		other deposit withdraws					
	in the inner-offic						
	requested formal	internal investigation."					
	H. BDDS report	t dated 7/19/11: "Staff					
	_	Coordinator that when					
		eank with a client (client					
	#4) that there see	emed to be money					
	missing from his	accountService					
	_	ted gathering information					
		/11 received bank					
	statement in office	ce: 7/17/11 conducted					
	internal investigation and found monies to						
		visiting group home;					
	_	other deposit withdraws					
	in the inner-offic						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475			LDING	ONSTRUCTION  00	(X3) DATE COMPI 10/07/2	LETED	
NAME OF	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP CODE	•	
ARC BR	RIDGES INC				LLSWORTH CT LLVILLE, IN46410		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION
TAG		l internal investigation."		TAG	BLA (CLACE)		DATE
	Further review of indicated:	of the investigation record					
	Sheet: "Incident 15539[Client # 6/30/11Someo out of [client #4]	ne has made withdrawals  account." Further  port failed to indicate the					
	Sheet: "Incident 15538[Client # 6/30/11Someo on 4/9/11 or 4/1 account." Furth	ncident Report Summary t Report Number: #1]Date: one has made withdrawal 1/11 out of [client #1] er review of the report te the amount of money					
	Sheet: "Incident 15540[Client # 6/30/11Someo out of his account	one has made withdrawals nt." Further review of the ndicate the amount of					
	Sheet: "Incident 15541[Client #	ncident Report Summary t Report Number: #2]Date: one has made withdrawals					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G475	B. WIN			10/07/2	011
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	K		5777 El	LSWORTH CT		
	IDGES INC			MERRII	LVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIACI )		DATE
	-	savings account."					
		of the report failed to					
	indicate the amount of money withdrawn.						
	Review of the SC notes dated 7/17/11						
		deposit slips for 4/11/11					
		l gentlemanBudgets					
		not done)\$35.00 x 3					
	· ·	.00 x 4 missing." Further					
	_	<u> </u>					
	review failed to indicate what amount						
	belonged to each	i chent.					
	A review of the	clients' personal financial					
		24/11 to 9/30/11 was					
	conducted on 10	0/4/11 at 11:50 A.M					
		#1's record failed to					
		entioned withdrawals or a					
		nent from the facility for					
		Review of client #2's					
		indicate the mentioned					
		a cash reimbursement					
		for missing funds.					
	-	t #3's record failed to					
		tioned withdrawals or a					
		nent from the facility for					
		Review of client #4's					
	_	indicate the mentioned					
		a cash reimbursement					
	irom the facility	for missing funds.					
	An interview wi	th the Service					
	Coordinator (SC	() was conducted on					
	`	P.M The SC indicated					
		cial records should reflect					
	1						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/07/2011
	PROVIDER OR SUPPLIER		STREET . 5777 E	ADDRESS, CITY, STATE, ZIP CODE ELLSWORTH CT ELLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE
W0149	and when funds a clients' personal further indicated reflective on each financial records  9-3-2(a)  The facility must dwritten policies and mistreatment, neg  Based on record facility neglected abuse/neglect poreport, to the facility of 3 injuries of uninvolved 1 of 2 sthe group home (5 clients residing (clients #1, #2, # neglected to impless the group thandling Cases of the group thandling than the group than	evelop and implement d procedures that prohibit lect or abuse of the client.  review and interview, the I to implement their licy to immediately flity's administrator: 1. 1 nknown origin which ampled clients living at (client #1 and 2.) for 4 of at the group home 3 and #4), the facility lement its "Policy For of Neglect and Abuse" by f did not financially s.	W0149	Service Coordinator will train DSP's on proper reporting procedures. To ensure future compliance Service Coordinator will revincidents reports when recent missing money for client, 2, 3, & 4 were reimbursed October 7, 2011.	e, iew ived.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CPKK11 Facility ID:

000989

If continuation sheet

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		LDING	NSTRUCTION  00	(X3) DATE COMPI 10/07/2	LETED
	PROVIDER OR SUPPLIER		1	STREET A	LDDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	were reviewed of The review indice of unknown orige "Name: [Client at 05/27/2011, Dat 05/31/2011, Name: [client #1] with a bruise on [client [client #1] how he (client #1] how he (client #1) stated Plan to Resolve: incident report at the Community at the Coordinator #1 areceive the report internal investigated determine the origination."  Service Coordinator at 11 at 11: Coordinator #1 in client #1's hip was not notified until 5/31/11.  The facility's recommunity in the facility's recommunity in the facility's recommunity at the facility's recommunity in the facility in the facility's recommunity in the facility in the facili	om 10/1/10 to 10/3/11, in 10/3/11 at 2:06 P.M stated the following injury in involving client #1: #1], Incident Date: te of knowledge: trative: While assisting in bath, staff noticed a #1's] left hip. Staff asked the got the bruise and he that he did not know. Staff filled out a (sic) and sent it in the mail to Services Nurse (Nurse holiday weekend and the tis new, we (Service and Nurse #3) did not at until 5/21/11. An action has been started to tigin of the bruise, will the results upon the staff on facility's administrator of the injury to client #1 words were further					
	reviewed on 10/4	4/11 at 2:52 P.M					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CPKK11 Facility ID:

000989

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE : COMPL 10/07/2	ETED	
	PROVIDER OR SUPPLIEI	3	•	5777 EL	DDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410		
				l			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Handling Cases dated 12/20/200 following: "The or who has becomust immediate his/her immedia suspected incide 2. A review of the conducted on 10 Review of the farecord indicated reports and Bure Disabilities Serv which indicated A. Incident/Accand 4/11/11 out or accountReport (SC)To (sic) in to the clients mor separation of durther report failed money withdraw B. Incident/Accand 3/23/11: "S withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal out of accountReport (SC)To (sic) in the clients more withdrawal ou	the facility's records was 1/4/11 at 10:40 A.M acility's investigation internal incident/accident rau of Developmental rices (BDDS) reports the following:  Additional control of the facility of the following:  Additional control of the facility of the					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  10/07/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
ARC BRI	DGES INC			ILLSWORTH CT ILLVILLE, IN46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	separation of dut the report failed money withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut the report failed money withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut the report failed money withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut the report failed money withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut the report failed money withdrawals.  E. BDDS report notified Service she went to the b #1) that there see missing from his Coordinator start to account: 7/12 statement in office	ies." Further review of to indicate the amount of in.  ident report dated 4/11/11 omeone has made of [client #3]'s to Service Coordinator many people have access mey. There is no ies." Further review of to indicate the amount of in.  ident report dated one has made of [client #4]'s savings to Service Coordinator many people have access mey. There is no ies." Further review of its indicate the amount of in.  ident report dated one has made of [client #4]'s savings to Service Coordinator many people have access mey. There is no ies." Further review of its indicate the amount of in.  dated 7/19/11: "Staff Coordinator that when mank with a client (client emed to be money accountService ited gathering information infor	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	_	ation and found monies to visiting group home;			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G475		A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMPI 10/07/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG	7/18/11 received in the inner-offic requested formal  F. BDDS report notified Service she went to the b #2) that there see missing from his Coordinator start to account: 7/12 statement in offic internal investigate missing after 7/18/11 received in the inner-offic requested formal  G. BDDS report notified Service she went to the b	other deposit withdraws the mail. 7/19/11 Internal investigation."  dated 7/19/11: "Staff Coordinator that when bank with a client (client temed to be money accountService thed gathering information //11 received bank there: 7/17/11 conducted fation and found monies to visiting group home; other deposit withdraws		TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	KALE	DATE
	missing from his Coordinator start to account: 7/12 statement in officinternal investigate missing after 7/18/11 received in the inner-offic requested formal H. BDDS report	accountService ted gathering information /11 received bank ce: 7/17/11 conducted ation and found monies to visiting group home; other deposit withdraws					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/07/2	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5777 ELLSWORTH CT  MERRILLVILLE, IN46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	) BE	(X5) COMPLETION DATE
	#4) that there see missing from his Coordinator start to account: 7/12 statement in offi internal investigate missing after 7/18/11 received in the inner-offic requested formal.  Further review of indicated:  1. Staff/Client In Sheet: "Incident 15539[Client #4] review of the regamount of mone.  2. Staff/Client In Sheet: "Incident 15538[Client #4] review of the regamount of mone.  2. Staff/Client In Sheet: "Incident 15538[Client #6/30/11Someo on 4/9/11 or 4/11 account." Further failed to indicate withdrawn.	Internal investigation."  If the investigation record  Incident Report Summary  Report Number:  If JDate: Ine has made withdrawals I account." Further I port failed to indicate the I wy withdrawn.  Incident Report Summary I Report Number:					
		Report Number:					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	` <i>′</i>	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		LETED
		15G475	B. WIN	G		10/07/2	2011
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
ADC DD	IDOEC INC				LLSWORTH CT		
ARC BR	IDGES INC			MERKII	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROI		COMPLETION DATE
TAG		·		TAG			DATE
	15540[Client #	-					
	6/30/11Someone has made withdrawals out of his account." Further review of the						
		ndicate the amount of					
	money withdraw						
	money withdraw	VII.					
	1 Staff/Client I	ncident Report Summary					
		t Report Number:					
	15541[Client #	•					
	_	=					
	6/30/11Someone has made withdrawals out of [client #2] savings account."						
	Further review of the report failed to						
	indicate the amount of money withdrawn.						
	maleate the ame	duit of money withdrawn.					
	Review of the S	C notes dated 7/17/11					
		deposit slips for 4/11/11					
		ll gentlemanBudgets					
		not done)\$35.00 x 3					
	,	0.00 x 4 missing." Further					
	•	indicate what amount					
	belonged to each						
	Schonged to ouch						
	A review of the	clients' personal financial					
		24/11 to 9/30/11 was					
		0/4/11 at 11:50 A.M					
		t #1's record failed to					
		reimbursement from the					
		ing funds. Review of					
	_	d failed to indicate a cash					
		from the facility for					
		Review of client #3's					
	record failed to						
		from the facility for					
		Review of client #4's					
	3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 -				<u> </u>		1

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MU A. BUILI B. WING	DING	nstruction 00	(X3) DATE : COMPL 10/07/2	ETED	
			D. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			LSWORTH CT		
ARC BR	IDGES INC				LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	<b> </b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	record failed to i						
	reimbursement from the facility for						
	missing funds.						
	A review of the	facility's "Policy for					
	Handling Cases	of Neglect and Abuse"					
	dated 12/20/08 v	vas conducted on 10/4/11					
	at 12:50 P.M. an	d indicated: "In order to					
	protect the gener	al welfare of the clients,					
	[Facility name] l	nas in effect the following					
	policy with regar	rd to abuse, neglect or					
	exploitation of c	lients by agency staff					
	[Facility name] p	prohibits all abuse,					
	neglect and expl	oitation of our					
	clientsStaff wi	ll immediately report any					
	allegations of ab	use, neglect or					
	exploitation of o	ur clients per agency					
	reporting proced	ureAll allegations of					
	abuse, neglect, h	umiliation or exploitation					
	will be investiga	tedExploitation-is					
	defined as the ur	nauthorized use or misuse					
	of a client's labor	r, funds, property or other					
	assets for one's o	own profit or advantage.					
	Examples includ	e but are not limited to					
	using their finan	ces without					
	permissionThe	_					
	1	nvestigation will submit					
		ssurance Specialist or					
	_	on as possible (preferably					
	within 24 hours)	a written summary of					
	any and all infor	mation gathered with					
	regard to the inc	identUpon receipt of the					
	final report, the	Quality Assurance					
	Specialist or des	ignee will complete the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CPKK11 Facility ID:

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 10/07/2011			
	ROVIDER OR SUPPLIER		5777 EI	ADDRESS, CITY, STATE, ZIP CODE LLSWORTH CT LLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	necessary follow (and thereafter as	-up report within 5 days s needed)."			
	10/4/11 at 12:20 the reporting staff to her on 6/30/11 the bank statement withdrawals. The investigation was 10/4/11 the client reimbursed for the	o was conducted on P.M The SC indicated for reported the incidents but she had to wait for ints to come to verify the e SC indicated the still open and as of			
W0153	mistreatment, neglinjuries of unknow	nsure that all allegations of lect or abuse, as well as n source, are reported administrator or to other			
	Based on record facility failed to i	review and interview, the immediately report, to the trator, 1 of 3 injuries of	W0153	See tag # 149, p. 2	11/07/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G475	B. WIN			10/07/2	011
E 65.			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF E	PROVIDER OR SUPPLIE	K		5777 EI	LLSWORTH CT		
ARC BRI	IDGES INC			MERRII	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		which involved 1 of 2					
	•	living at the group home					
	(client #1) in accordance with state law.						
	Findings include:						
	The facility's inc	eident renorts					
	abuse/neglect all	•					
	_	rom 10/1/10 to 10/3/11,					
		on 10/3/11 at 2:06 P.M					
		cated the following injury					
		gin involving client #1:					
	_	#1], Incident Date:					
	_	te of knowledge:					
	· ·	<u> </u>					
	· ·	rrative: While assisting					
		a bath, staff noticed a					
	-	#1's] left hip. Staff asked					
		he got the bruise and he					
	` ′	I that he did not know.					
		Staff filled out a (sic)					
	incident report a	nd sent it in the mail to					
	1	Services Nurse (Nurse					
	#3.) Due to the	holiday weekend and the					
	fact that the staff	f is new, we (Service					
	Coordinator #1 a	and Nurse #3) did not					
		rt until 5/21/11. An					
		ation has been started to					
	_	rigin of the bruise, will					
	follow up with the	_					
	completion."	no resum apon					
	Compiction.						
	Sarvice Coordin	ator #1 was interviewed					
		:52 A.M Service					
	Coordinator #1 1	indicated the bruise to					

NAME OF PROVIDER OR SUPPLIER  ARC BRIDGES INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  client #1's hip was discovered by staff on  STREET ADDRESS, CITY, STATE, ZIP CODE  5777 ELLSWORTH CT MERRILLVILLE, IN46410  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	5777 ELLSWORTH CT
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH OERFICTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
client #1's hip was discovered by staff on	MUST BE PERCEDED BY FULL PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION
S/27/11 and the facility's administrator was not notified of the injury to client #1 until 5/31/11.	discovered by staff on cility's administrator  The injury to client #1  Wolfst administrator  Allegations of financial exploitation will be turned into the Quality Assurance Director within 24 hours of notification for investigation.  To ensure future compliance, all incident reports will be reviewed as received.  See attached procedures.  Seility's records was //11 at 10:40 A.M lity's investigation ternal incident/accident as (BDDS) reports to following:  ent report dated 4/9/11 of referral 6/30/11: let withdrawal on 4/9/11 client #1]'s service Coordinator my people have access by. There is no

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475	LDING	NSTRUCTION  00	CON	TE SURVEY MPLETED 7/2011
	PROVIDER OR SUPPLIEF	2	5777 EL	DDRESS, CITY, STATE, ZIP ( LSWORTH CT LVILLE, IN46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the report failed money withdraw	to indicate the amount of vn.				
	and 3/23/11: "So withdrawal out of accountReport (SC)To (sic) m to the clients mo separation of dut	ident report dated 4/11/11 comeone has made of [client #2]'s savings to Service Coordinator hany people have access ney. There is no ties." Further review of to indicate the amount of vn.				
	and 5/23/11: "So withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut	to Service Coordinator nany people have access ney. There is no ties." Further review of to indicate the amount of				
	4/11/11: "Some withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut the report failed money withdraw	of [client #4]'s savings to Service Coordinator nany people have access ney. There is no ties." Further review of to indicate the amount of				

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G475	B. WIN	G		10/07/2	011
NAME OF I	PROVIDER OR SUPPLIEF	\ \			ADDRESS, CITY, STATE, ZIP CODE		
ADC DD	IDGES INC				LLSWORTH CT LLVILLE, IN46410		
					LEVILLE, IN40410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	notified Service	Coordinator that when					
		eank with a client (client					
		emed to be money					
	missing from his accountService						
	Coordinator started gathering information						
	to account: 7/12/11 received bank						
	statement in offi						
	internal investiga						
	be missing after						
	7/18/11 received other deposit withdraws						
	in the inner-office mail. 7/19/11						
	requested formal internal investigation."						
	•	dated 7/19/11: "Staff					
		Coordinator that when					
		eank with a client (client					
	· ·	emed to be money					
	_	accountService					
		ted gathering information					
		/11 received bank					
		ce: 7/17/11 conducted					
	_	ation and found monies to					
	_	visiting group home;					
	in the inner-office	other deposit withdraws					
	requested formal	internal investigation."					
	7 BDDS report	dated 7/19/11: "Staff					
	-	Coordinator that when					
		eank with a client (client					
		emed to be money					
	· ·	accountService					
	_	ted gathering information					
		/11 received bank					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		LDING	NSTRUCTION  00	(X3) DATE COMPI 10/07/2	LETED
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	LDDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
IAU	statement in officinternal investigate missing after 7/18/11 received in the inner-officine requested formal 8. BDDS report notified Service she went to the buffle went to the buffle formal to account: 7/12 statement in officinternal investigate missing after 7/18/11 received in the inner-officine requested formal Further review of indicated:  1. Staff/Client In Sheet: "Incident 15539[Client #6/30/11Someone	ce: 7/17/11 conducted ation and found monies to visiting group home; other deposit withdraws the mail. 7/19/11 internal investigation."  dated 7/19/11: "Staff Coordinator that when wank with a client (client emed to be money accountService the gathering information /11 received bank the ce: 7/17/11 conducted ation and found monies to visiting group home; other deposit withdraws the mail. 7/19/11 internal investigation."  If the investigation record the investigation record mediant Report Summary Report Number: 44]Date: the has made withdrawals		IAG	DETCLINCT)		DATE
	review of the rep amount of mone	ncident Report Summary					
	Sheet: "Incident	Report Number:					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION  00	(X3) DATE (COMPL)  10/07/2	ETED	
NAME OF	PROVIDER OR SUPPLIER	₹			.DDRESS, CITY, STATE, ZIP CODE LSWORTH CT		
ARC BR	IDGES INC			MERRIL	LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	on 4/9/11 or 4/1 account." Furth	#1]Date: ne has made withdrawal 1/11 out of [client #1] er review of the report e the amount of money					
	3. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15540[Client #3]Date: 6/30/11Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.						
	Sheet: "Incident 15541[Client # 6/30/11Someo out of [client #2] Further review of	ncident Report Summary t Report Number: #2]Date: ne has made withdrawals ] savings account." of the report failed to ount of money withdrawn.					
	10/4/11 at 12:20 the reporting sta to her on 6/30/11 the bank statements	th the Service  b) was conducted on  P.M The SC indicated  ff reported the incidents  but she had to wait for  ents to come to verify the  ore conducting an					
	9-3-2(a)						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE COMP 10/07/2	LETED	
	PROVIDER OR SUPPLIER		STREET A 5777 EI	ADDRESS, CITY, STATE, ZIP CO LLSWORTH CT LLVILLE, IN46410	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W0156	reported to the adrepresentative or the accordance with Strategy of the incider.  Based on record 1 of 1 investigation of 5 clients (client facility failed to a investigation to the five working day.  Findings include:  A review of the factor of the fact	tate law within five working att.  review and interview for on records, involving 4 ats #1, #2, #3 and #4), the report the results of the he administrator within as of the incident.  Cacility's records was (4/11 at 10:40 A.M cility's investigation internal incident/accident au of Developmental aces (BDDS) reports the following:  dent report dated 4/9/11 at of referral 6/30/11: ade withdrawal on 4/9/11	W0156	See tag 104, p. 2		11/07/2011
	accountReport (SC)To (sic) m to the clients more	to Service Coordinator any people have access				

	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COM	E SURVEY PLETED
		15G475	B. WIN			10/07	2011
	PROVIDER OR SUPPLIEF	3		5777 EL	.DDRESS, CITY, STATE, ZIP ( .LSWORTH CT .LVILLE, IN46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the report failed money withdraw	to indicate the amount of rn.					
	and 3/23/11: "So withdrawal out of accountReport (SC)To (sic) m to the clients moseparation of durant control of the clients moseparation control of the clients moseparation control of the clients moseparation control of the clients and control of the clients moseparation control of the clients moseparation control of the clients and control of the clients moseparation control of the clients moseparation control of the clients and control of the clients moseparation control of the clients and control of the clients moseparation control of the clients and control of the clients moseparation control of the clients and control	dent report dated 4/11/11 omeone has made of [client #2]'s savings to Service Coordinator any people have access ney. There is no ties." Further review of to indicate the amount of m.					
	and 5/23/11: "So withdrawals out accountReport (SC)To (sic) m to the clients moseparation of duty	to Service Coordinator nany people have access ney. There is no ties." Further review of to indicate the amount of					
	4/11/11: "Some withdrawals out accountReport (SC)To (sic) m to the clients mo separation of dut the report failed money withdraw	of [client #4]'s savings to Service Coordinator nany people have access ney. There is no ties." Further review of to indicate the amount of					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G475	B. WIN	G		10/07/2	011
NAME OF I	PROVIDER OR SUPPLIEF	\ \			ADDRESS, CITY, STATE, ZIP CODE		
ADC DD	IDGES INC				LLSWORTH CT LLVILLE, IN46410		
					LEVILLE, IN40410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	notified Service	Coordinator that when					
		eank with a client (client					
		emed to be money					
	missing from his accountService						
	Coordinator started gathering information						
	to account: 7/12/11 received bank						
	statement in offi						
	internal investiga						
	be missing after						
	7/18/11 received other deposit withdraws						
	in the inner-office mail. 7/19/11						
	requested formal internal investigation."						
	•	dated 7/19/11: "Staff					
		Coordinator that when					
		eank with a client (client					
	· ·	emed to be money					
	_	accountService					
		ted gathering information					
		/11 received bank					
		ce: 7/17/11 conducted					
	_	ation and found monies to					
	_	visiting group home;					
	in the inner-office	other deposit withdraws					
	requested formal	internal investigation."					
	7 BDDS report	dated 7/19/11: "Staff					
	-	Coordinator that when					
		eank with a client (client					
		emed to be money					
	· ·	accountService					
	_	ted gathering information					
		/11 received bank					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 10/07/2011
	PROVIDER OR SUPPLIEF	2	5777 El	ADDRESS, CITY, STATE, ZIP LLSWORTH CT LLVILLE, IN46410	CODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
TAG	statement in offi internal investigation the inner-office requested formal.  8. BDDS report notified Service she went to the best wasted from the insisting from his Coordinator start to account: 7/12 statement in offi internal investigation be missing after 7/18/11 received in the inner-office requested formal.  Further review of indicated:  1. Staff/Client I Sheet: "Incident 15539[Client #4] review of the reparamount of mone.  2. Staff/Client I staff/Client I should be more.	ce: 7/17/11 conducted ation and found monies to visiting group home; dother deposit withdraws are mail. 7/19/11 linternal investigation."  dated 7/19/11: "Staff Coordinator that when bank with a client (client accountService accountService accountService acted gathering information and found monies to visiting group home; dother deposit withdraws are mail. 7/19/11 linternal investigation."  of the investigation record account." Further account." Further bort failed to indicate the	IAU		

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIE		(X2) MUI	LTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUM	BER:	A. BUILE	DING	00		COMPL	
		15G475		B. WING				10/07/2	011
NAME OF P	ROVIDER OR SUPPLIER					ADDRESS, CITY, STA			
						LSWORTH CT			
ARC BRII	DGES INC				MERRIL	LVILLE, IN4641	10		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIEN	NCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PERCEDED		P	REFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFO	ORMATION)		TAG	DEF	ICIENCY)		DATE
	15538[Client #	-	1						
		ne has made withd							
		1/11 out of [client #	_						
		er review of the rep							
	failed to indicate the amount of money								
	withdrawn.								
	2 Cta SS/Client In aid ant Dan art School and								
	3. Staff/Client Incident Report Summary								
	Sheet: "Incident Report Number:								
	15540[Client #3]Date:								
	6/30/11Someone has made withdrawals								
	out of his account." Further review of the								
	-	ndicate the amount	of						
	money withdraw	/n.							
	4 Staff/Client I	ncident Report Sun	nmary						
		t Report Number:	ililiai y						
	15541[Client #	•							
	-	ne has made withd	rawale						
		savings account."							
		of the report failed t							
		ount of money with							
	marcate the amo	unt of money with	arawii.						
	An interview wi	th the Service							
		() was conducted or	n						
	`	P.M The SC ind							
		ff reported the incid							
		but she had to wa							
		ents to come to veri							
		ore conducting an	<i>J</i>						
		he SC further indic	ated						
	<del>-</del>	ninistrator was not							
	-	tigative finding wit	thin						
		ys of the incident.							
FORM CMS-2:	567(02-99) Previous Versi		Event ID: C	PKK11	Facility I	ID: 000989	If continuation sh	eet Pa	ge 34 of 48

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPL 10/07/2	ETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	9-3-2(a)						
W0157	If the alleged viola corrective action n	tion is verified, appropriate nust be taken.	W	)157	See W 154 & W 9999 See tag 104		11/07/2011
	facility failed for the group home (	review and interview, the 4 of 5 clients residing in (clients #1, #2, #3 and #4) corrective action for ons of financial					
	Findings include	:					
	conducted on 10/ Review of the factorial record indicated reports and Bure.	Pacility's records was 4/11 at 10:40 A.M cility's investigation internal incident/accident au of Developmental ices (BDDS) reports the following:					
	and 4/11/11, date "Someone has m or 4/11/11 out of accountReport (SC)To (sic) m to the clients more separation of dut	to Service Coordinator any people have access					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE : COMPL 10/07/2	ETED	
NAME OF	PROVIDER OR SUPPLIEF	3	•	5777 EL	DDRESS, CITY, STATE, ZIP CODE LSWORTH CT		
ARC BR	RIDGES INC			MERRIL	LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	was available for	n. No documentation review to indicate the ective corrective action at.					
	and 3/23/11: "Swithdrawal out of accountReport (SC)To (sic) me to the clients more separation of during report failed to it money withdraw was available for facility took effer after this incident. 3. Incident/Acci and 5/23/11: "Swithdrawals out accountReport (SC)To (sic) me to the clients more separation of during report failed to it.	ident report dated 4/11/11 omeone has made					
	was available for facility took effer after this incider.  4. Incident/Accid/11/11: "Some	r review to indicate the ective corrective action at.					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		A. BUI	LDING	NSTRUCTION 00		E SURVEY LETED 2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CO LLSWORTH CT LLVILLE, IN46410		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	accountReport (SC)To (sic) m to the clients more separation of dut report failed to in money withdraw was available for facility took effer after this incident.  5. BDDS report notified Service is she went to the braining from his Coordinator start to account: 7/12 statement in officinternal investigate be missing after 7/18/11 received in the inner-officing requested formal No documentation review to indicate effective correcting incident.  6. BDDS report notified Service is she went to the braining from his missing from his missing from his	to Service Coordinator any people have access ney. There is no ies." Review of the ndicate the amount of n. No documentation review to indicate the ective corrective action t.  dated 7/19/11: "Staff Coordinator that when ank with a client (client emed to be money accountService red gathering information /11 received bank tee: 7/17/11 conducted ation and found monies to visiting group home; other deposit withdraws					

000989

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (10/07/2011)				ETED	
			B. WIN		DDDECC CITY CTATE 7ID CODE	10,01,2	· · ·
NAME OF I	PROVIDER OR SUPPLIEF	8		1	DDRESS, CITY, STATE, ZIP CODE  LSWORTH CT		
ARC BR	IDGES INC				LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		/11 received bank		TAG	BEI ICIENCT)		DATE
	statement in office: 7/17/11 conducted internal investigation and found monies to						
	_	visiting group home;					
	_	other deposit withdraws					
	in the inner-office	•					
		internal investigation."					
	_	on was available for					
		te the facility took					
		ive action after this					
	incident.						
	7. BDDS report	dated 7/19/11: "Staff					
	_	Coordinator that when					
	she went to the b	eank with a client (client					
		emed to be money					
	missing from his	accountService					
	Coordinator star	ted gathering information					
	to account: 7/12	/11 received bank					
	statement in offi	ce: 7/17/11 conducted					
	internal investiga	ation and found monies to					
	be missing after	visiting group home;					
		other deposit withdraws					
	in the inner-office						
	*	internal investigation."					
		on was available for					
		e the facility took					
		ive action after this					
	incident.						
	0 DDD0	Jan J 7/10/11. 1104 - CC					
	_	dated 7/19/11: "Staff					
		Coordinator that when					
		oank with a client (client					
	#4) that there see	emed to be money					

000989

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	f '	E SURVEY PLETED	
12.21		15G475	A. BUILI			- 10/07/	
			B. WING		DDRESS, CITY, STATE, ZIP C		
NAME OF I	PROVIDER OR SUPPLIEI	₹			LSWORTH CT		
ARC BR	IDGES INC			MERRIL	LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORI		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	s accountService ted gathering information					
		•					
	to account: 7/12/11 received bank statement in office: 7/17/11 conducted						
		ation and found monies to					
	_	visiting group home;					
	_	l other deposit withdraws					
	in the inner-offic	ce mail. 7/19/11					
	requested forma	l internal investigation."					
	No documentation was available for						
	review to indicate the facility took						
	effective corrective action after this						
	incident.						
	Eurther reviews	f the investigation record					
	indicated:	of the investigation record					
	marcatca.						
	1. Staff/Client I	ncident Report Summary					
		t Report Number:					
	15539[Client #	#4]Date:					
	6/30/11Someo	ne has made withdrawals					
		account." Further					
		port failed to indicate the					
	amount of mone	y withdrawn.					
	2 Staff/Cliant I	ncident Report Summary					
		t Report Number:					
	15538[Client #	1					
	_	ne has made withdrawal					
		1/11 out of [client #1]					
		er review of the report					
		e the amount of money					
	withdrawn.	·					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G475	B. WIN	G		10/07/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
ADC DD	DOEC INC				LSWORTH CT		
	DGES INC				LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ncident Report Summary		1710			DATE
		Report Number:					
	15540[Client #	*					
	_	ne has made withdrawals					
		nt." Further review of the					
		ndicate the amount of					
	money withdraw						
	money witharaw	11.					
	4 Staff/Client I	ncident Report Summary					
		Report Number:					
	15541[Client #	•					
	_	ne has made withdrawals					
		savings account."					
		of the report failed to					
		unt of money withdrawn.					
		,					
	Review of the So	C notes dated 7/17/11					
	indicated: "No o	deposit slips for 4/11/11					
	or 5/23/11 for al	l gentlemanBudgets					
	were available-(	not done)\$35.00 x 3					
	missing and \$50	.00 x 4 missing." Further					
	review failed to	indicate what amount					
	belonged to each	n client.					
	A review of the	clients' personal financial					
	records dated 6/2	24/11 to 9/30/11 was					
	conducted on 10	/4/11 at 11:50 A.M					
	Review of client	#1's record failed to					
	indicated a cash	reimbursement from the					
	facility for missi	ng funds. Review of					
	client #2's record	d failed to indicate a cash					
	reimbursement from the facility for						
	missing funds. I	Review of client #3's					
	record failed to i	ndicate a cash					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CO	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/07/2011			
NAME OF I	PROVIDER OR SUPPLIER		B. WING TO/O7/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  5777 ELLSWORTH CT				
ARC BR	DGES INC		MERRI	LLVILLE, IN46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
W0331	missing funds. R record failed to in reimbursement fin missing funds.  An interview with Coordinator (SC) 10/4/11 at 12:20 there was no door review to indicate effective correction.  9-3-2(a)  The facility must p services in accord.  Based on observating interview for 1 or group home (clie to provide nursing injury.  Findings include.  An evening obsetthe group home of P.M. until 8:30 P.M. until 8:30 P.M.	h the Service ) was conducted on P.M The SC indicated umentation available for e the facility took ve action.  rovide clients with nursing ance with their needs.  ation, record review and f 5 clients residing at the ent #4), the facility failed g services for the client's	W0331	By this incident not being ar emergency, the group home left a message with their tea nurse, which the nurse return their call later that evening. did not call the nurse emergicell phone due to the situation was non-emergency. Client seen by the podiatris the saiday. To ensure future complishe group home staff will be re-trained on the protocol for calling the nurse. A memory also be sent to all of resider broup homes to prevetn furtoccurrance.	e staff am rned Staff ecy on t was me iance, r will		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED			
		15G475	B. WIN			10/07/2011			
NAME OF S	DROWNER OF GUIDN 153				ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIE	K.		5777 ELLSWORTH CT					
ARC BRI	DGES INC			MERRILLVILLE, IN46410					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE			
	Direct Support F	Professional (DSP) #2 was			11/10/11 All DSPs are traine				
	observed to esco	ort client #4 into his			cores A&B of the Living in th Community Medical aspect of				
	bedroom. At 6:3	30 P.M., DSP #2			foundations. During this train				
	indicated client	#4's sock was soaked with			all staff is trained on assessi				
	blood from a pri	or injury he acquired by			and treating minor medical is				
	_	DSP #2 further			such as scrathces, bruises, e				
		lled the group home			and the differenc identifying				
		eal Nurse (LPN) and left a			emergency medical need. In				
		s awaiting a call back for			case, the client had a podiate appointment on the same da				
	_	S awaiting a can back for S staff did not return the			which when he got home the				
					band aid was bloody; and the				
	call by 8:30 P.M	l			were calling to notify the nur				
					they had changed the band a	aid.			
		facility's "When to Call a			Therefore, the staff followed	ting			
	•	e no date noted was			trained procedures in contact the nurse. Since the issue was				
	conducted on 10	0/4/11 at 12:50 P.M			non emergency call procedu	l l			
	review of the pro	ocedure indicated: "The			The Nurse correctly followed				
	Nurse assigned t	to the group home is to be			call back procedure by return	ning			
	contacted regard	ling any changes in a			the call. If this had been an a				
	_	condition. If no answer,			emergency, the group home				
		and wait 30 minutes for a			would have called the emerg nurse's cell phone, and the r	· .			
	_	the nurse's emergency			would be expected to return				
		alling a Nurse, there is a			call within 30 minutes. In add				
	30 minute respon				nurses and the group home				
	o minute respo	iise uiiie.			has been retrained on the ca	ll			
	A	4h 4h a Dimantan a CNI main			procedure to ensure a more	۱			
		th the Director of Nursing			timely response by a license medical professional.	u			
	· ·	ducted on 10/4/11 at 1:00			modiodi professional.				
		indicated nursing staff							
	_	within 30 minutes when							
		et them about medical							
	concerns in rega	rds to clients. When							
	asked if client #4	4 had been assessed by the							
	group home LPN, she indicated the group								
	home LPN had not assessed client #4's								
	injury but would	l do so after lunch. No							
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED  COMPLETED				
ANDILAN	OF CORRECTION	15G475	A. BUILDING B. WING 10/07/2011				
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			LLSWORTH CT			
ARC BRI	DGES INC		MERRI	LLVILLE, IN46410			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE		
1710		tation was available for	1710		DATE		
		e the group home LPN					
		group home call or					
	assessed client #4	-					
	9-3-6(a)						
W9999							
			W9999	Service Coordinator will be	11/07/2011		
	State Findings:			re-trained by the Quality Assurance Director to turn in follow up repor			
	The following Comr	munity Residential Facilities		within 7 days.			
		velopmental Disabilities rule		To ensure future compliance,			
	was not met:			Quality Assurance Director will			
	460 IAC 9-3-1(b)			monitor Bdds's follow up reports.			
		ider shall report the following					
		e division by telephone no later ss day followed by written					
	summaries as reques						
	This states a 1. is seen						
	I his state rule is not	met as evidence by:					
		iew and interview, the facility					
		estigation record of an					
		al exploitation reviewed ents residing at the group home					
		nd #4), to report Bureau of					
	Developmental Disa	abilities Services (BDDS)					
	follow up reports in	a timely manner					
	Findings include:						
		lity's records was conducted on M Review of the facility's indicated internal					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475			ĺ	LDING	NSTRUCTION  00	(X3) DATE COMPL 10/07/2	ETED
	PROVIDER OR SUPPLIEF	2		5777 EL	ADDRESS, CITY, STATE, ZIP CODE LLSWORTH CT LLVILLE, IN46410	•	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ON SHOULD BE COMPLETI	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE
		ports and Bureau of abilities Services (BDDS) ated the following:					
	4/11/11, date of reformade withdrawal or [client #1]'s account Coordinator (SC)' access to the clients separation of duties	nt report dated 4/9/11 and erral 6/30/11: "Someone has a 4/9/11 or 4/11/11 out of tReport to Service To (sic) many people have money. There is no ." Review of the report failed ant of money withdrawn.					
	3/23/11: "Someone [client #2]'s savings Coordinator (SC)' access to the clients separation of duties	the report dated 4/11/11 and the has made withdrawal out of accountReport to Service To (sic) many people have amoney. There is no Review of the report failed unt of money withdrawn.					
	5/23/11: "Someone [client #3]'s accoun Coordinator (SC)' access to the clients separation of duties	the report dated 4/11/11 and that made withdrawals out of tReport to Service  To (sic) many people have money. There is no  "Review of the report failed ant of money withdrawn.					
	"Someone has made #4]'s savings account Coordinator (SC)' access to the clients separation of duties	nt report dated 4/11/11: e withdrawals out of [client ntReport to Service To (sic) many people have money. There is no" Review of the report failed ant of money withdrawn.					
	Service Coordinator	ted 7/19/11: "Staff notified r that when she went to the client #1) that there seemed to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475			LDING	NSTRUCTION  00	(X3) DATE : COMPL 10/07/2	ETED	
	PROVIDER OR SUPPLIEF		•	5777 EL	ADDRESS, CITY, STATE, ZIP CODE LLSWORTH CT LLVILLE, IN46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Coordinator started account: 7/12/11 re office: 7/17/11 con and found monies to group home; 7/18/1 withdraws in the imprequested formal imprequested account: 7/12/11 re office: 7/17/11 con and found monies to group home; 7/18/1 withdraws in the imprequested formal imprequested formal imprequested formal imprequested formation was the facility submitted.  7. BDDS report data Service Coordinator started account: 7/12/11 re office: 7/17/11 con and found monies to group home; 7/18/1 withdraws in the imprequested formal impression i	gathering information to received bank statement in ducted internal investigation to be missing after visiting 1 received other deposit her-office mail. 7/19/11 ternal investigation." No available for review to indicate and a follow-up report.  The ded 7/19/11: "Staff notified or that when she went to the client #2) that there seemed to from his accountService gathering information to be missing after visiting 1 received other deposit her-office mail. 7/19/11 ternal investigation." No available for review to indicate and a follow-up report.  The ded 7/19/11: "Staff notified or that when she went to the client #3) that there seemed to from his accountService gathering information to be missing after visiting 1 received other deposit her-office mail. 7/19/11 ternal investigation." No available for review to indicate and a follow-up report.  The ded 7/19/11: "Staff notified or that when she went to the client #3) that there seemed to from his accountService gathering information to be missing after visiting 1 received other deposit her-office mail. 7/19/11 ternal investigation." No available for review to indicate and a follow-up report.  The ded 7/19/11: "Staff notified or the ded a follow-up report.  The ded 7/19/11: "Staff notified or the ded a follow-up report.  The ded 7/19/11: "Staff notified or review to indicate and a follow-up report.					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  10/07/2011				ETED	
	PROVIDER OR SUPPLIER			5777 ELI	DDRESS, CITY, STATE, ZIP CODE LSWORTH CT LVILLE, IN46410		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	bank with a client (a be money missing fi Coordinator started account: 7/12/11 re office: 7/17/11 condand found monies to group home; 7/18/1 withdraws in the intrequested formal int documentation was the facility submittee.  1. Staff/Client Incident Report Nu #4]Date: 6/30/11. withdrawals out of [review of the report of money withdrawals out of [review of the report of money withdrawals on 4/9/1]Date: 6/30/11. withdrawal on 4/9/1] account." Further reindicate the amount.  3. Staff/Client Incident Report Nu #3]Date: 6/30/11. withdrawals out of fi the report failed to in withdrawals.  4. Staff/Client Incident Report Nu #3]Date: 6/30/11.	r that when she went to the client #4) that there seemed to from his accountService gathering information to received bank statement in ducted internal investigation to be missing after visiting 1 received other deposit her-office mail. 7/19/11 ternal investigation." No available for review to indicate and a follow-up report.  The investigation record dent Report Summary Sheet: https://doi.org/10.1001/10.100					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G475		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING				(X3) DATE SURVEY COMPLETED 10/07/2011	
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE  5777 ELLSWORTH CT  MERRILLVILLE, IN46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR withdrawals out of	TATEMENT OF DEFICIENCIES  ACY MUST BE PERCEDED BY FULL  A LSC IDENTIFYING INFORMATION)  [client #2] savings account."  The report failed to indicate the withdrawn.		ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE A CROSS-REFERENCED DEFICII	TO THE APPROPRIAT	E	(X5) COMPLETION DATE
	Disabilities Service effective March 1, 2 at 5:00 P.M The policy of the Burear Services (BQIS) to and management sy ensuring the health receiving services a BDDSIncidents to any event or occurruncertainty resulting result in significant including but not line.  3. Alleged, suspector or Child Protective includes but is not late, unauthorized use it, personal services; ii. personal property iii. personal identity of an individual; b. other instance of for one 's own profor advantage of another the provider responsible Parties.	be reported to BQIS include ence characterized by risk or g in or having the potential to harm or injury to an individual mited to:  ed or actual exploitation (which ed to Adult Protective Services Services as indicated) which imited to:  of the:  y or finances; or  exploitation of an individual it or advantage or for the profit other.						
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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00		DATE SURVEY COMPLETED 0/07/2011
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO LSWORTH CT LVILLE, IN46410	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Initial incident rep	orting to BQIS					
	reportable incident, an incident initial re	of initial discovery of a the reporting person shall file port with BQIS using the ctronic format available at fssa.in.gov/IFUR/.					
	Reportable Inciden	t Follow-Up					
	reporting shall: a. submit an electron within 7 days of the report; b. continue to submit an every 7 day scheduler.	nsible for incident follow-up nic incident follow-up report date of the incident initial it incident follow-up reports on dule, until such time as the to the satisfaction of all					
	was conducted on 1 indicate no follow u further documentation	ne Service Coordinator (SC) 0/4/11 at 12:20 P.M The SC p reports were submitted. No on was available for review to eports were submitted timely to					